

		FOR OHF USE					

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**2000**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2000)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH Facility ID Number:</b> <u>0044453</u></p> <p><b>Facility Name:</b> <u>NORTHSHORE NURSING &amp; REHABILITATION</u></p> <p><b>Address:</b> <u>2222 West 14th Street</u> <u>Waukegan</u> <u>60085</u>          Number City Zip Code</p> <p><b>County:</b> <u>Lake</u></p> <p><b>Telephone Number:</b> <u>(847) 249-2400</u> <b>Fax #</b> <u>(847) 249-0536</u></p> <p><b>IDPA ID Number:</b> <u>36-4302186-001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>8/01/99</u></p> <p><b>Type of Ownership:</b></p> <table> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Steve N. Lavenda</u> <b>Telephone Number:</b> <u>(847) 236-1111</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/00</u> to <u>12/31/00</u> and certify to the best of my knowledge and belief that the said content: are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment</p> <table> <tr> <td rowspan="2"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="4"><b>Paid Preparer</b></td> <td>(Type or Print Name) _____</td> </tr> <tr> <td>(Title) _____</td> </tr> <tr> <td>(Signed) <u>SEE ACCOUNTANT'S REPORT ATTACHED</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="4"><b>Paid Preparer</b></td> <td>(Print Name and Title) <u>Edward Slack, C.P.A.</u></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>FROST, RUTTENBERG &amp; ROTHBLATT, P.C.</u> <u>111 Pfingsten Rd. , Suite 300, Deerfield, IL 60015</u></td> </tr> <tr> <td>(Telephone) <u>(847) 236-1111</u> <b>Fax #</b> <u>(847) 236-1155</u></td> </tr> <tr> <td><b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> 201 S. Grand Avenue East Springfield, IL 62763-0001 <b>Phone #</b> (217) 782-1630</td> </tr> </table>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____	<b>Paid Preparer</b>	(Type or Print Name) _____	(Title) _____	(Signed) <u>SEE ACCOUNTANT'S REPORT ATTACHED</u>	(Date) _____	<b>Paid Preparer</b>	(Print Name and Title) <u>Edward Slack, C.P.A.</u>	(Firm Name & Address) <u>FROST, RUTTENBERG &amp; ROTHBLATT, P.C.</u> <u>111 Pfingsten Rd. , Suite 300, Deerfield, IL 60015</u>	(Telephone) <u>(847) 236-1111</u> <b>Fax #</b> <u>(847) 236-1155</u>	<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> 201 S. Grand Avenue East Springfield, IL 62763-0001 <b>Phone #</b> (217) 782-1630
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Facility Name & ID Number NORTHSHORE NURSING & REHABILITATION# 0044453 Report Period Beginning: 01/01/00 Ending: 12/31/00

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>125</u>	Skilled (SNF)	<u>125</u>	<u>45,750</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>146</u>	Intermediate (ICF)	<u>146</u>	<u>53,436</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>271</u>	TOTALS	<u>271</u>	<u>99,186</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>20,671</u>	<u>1,677</u>	<u>5,589</u>	<u>27,937</u>	8
9	SNF/PED					9
10	ICF	<u>37,542</u>	<u>2,468</u>	<u>1,490</u>	<u>41,500</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>58,213</u>	<u>4,145</u>	<u>7,079</u>	<u>69,437</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 70.01%

D. How many bed-hold days during this year were paid by Public Aid?

NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/A

F. Does the facility maintain a daily midnight census?

YESG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 8/1/99

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 8/1/99NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 22

and days of care provided

4,288Medicare Intermediary AdminaStar Federal

## IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH\* ☐CASH\* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/00Fiscal Year: 12/31/00

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

Page 3

Facility Name & ID Number NORTHSHORE NURSING & REHABILIT/ # 0044453 Report Period Beginning: 01/01/00 Ending: 12/31/00

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
1	Dietary	239,965	62,185	15,279	317,429		317,429	(407)	317,022			1
2	Food Purchase		288,884		288,884	(41,812)	247,072	46	247,118			2
3	Housekeeping	255,698	84,761		340,459		340,459		340,459			3
4	Laundry	73,149	60,877		134,026		134,026		134,026			4
5	Heat and Other Utilities			167,060	167,060		167,060		167,060			5
6	Maintenance	56,695		53,643	110,338		110,338	1	110,339			6
7	Other (specify):*							11	11			7
8	<b>TOTAL General Services</b>	625,507	496,707	235,982	1,358,196	(41,812)	1,316,384	(349)	1,316,035			8
9	<b>B. Health Care and Programs</b>											
9	Medical Director			13,640	13,640		13,640		13,640			9
10	Nursing and Medical Records	2,370,337	146,452	37,741	2,554,530		2,554,530	(33,017)	2,521,513			10
10a	Therapy	125,516		2,250	127,766		127,766		127,766			10a
11	Activities	138,254	10,168	2,752	151,174		151,174		151,174			11
12	Social Services	67,140		1,250	68,390		68,390		68,390			12
13	Nurse Aide Training											13
14	Program Transportation			104	104		104		104			14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	2,701,247	156,620	57,737	2,915,604		2,915,604	(33,017)	2,882,587			16
17	<b>C. General Administration</b>											
17	Administrative	62,885		36,000	98,885		98,885	6	98,891			17
18	Directors Fees											18
19	Professional Services			72,956	72,956		72,956	(53,045)	19,911			19
20	Dues, Fees, Subscriptions & Promotions			88,619	88,619		88,619	(53,685)	34,934			20
21	Clerical & General Office Expenses	178,844	37,585	110,969	327,398		327,398	(37,646)	289,752			21
22	Employee Benefits & Payroll Taxes			518,881	518,881	41,812	560,693		560,693			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,131	3,131		3,131	(1,186)	1,945			24
25	Other Admin. Staff Transportation			1,968	1,968		1,968	10	1,978			25
26	Insurance-Prop.Liab.Malpractice			180,282	180,282		180,282		180,282			26
27	Other (specify):*							4,401	4,401			27
28	<b>TOTAL General Administration</b>	241,729	37,585	1,012,806	1,292,120	41,812	1,333,932	(141,145)	1,192,787			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,568,483	690,912	1,306,525	5,565,920		5,565,920	(174,511)	5,391,409			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**NORTHSHORE NURSING & REHABILITATION**

**0044453**

**COST REPORT RECLASSIFICATIONS**

**01/01/00**

**12/31/00**

SCHEDULE V LINE #
----------------------

<table border="1"><tr><td>22</td></tr></table>	22	EMPLOYEE BENEFITS	<u>41,812</u>	
22				
<table border="1"><tr><td>2</td></tr></table>	2	FOOD		<u>41,812</u>
2				

To reclass cost of employee meals from raw food to employee benefits

<table border="1"><tr><td>33</td></tr></table>	33	REAL ESTATE TAX	<u>                    </u>	
33				
<table border="1"><tr><td>19</td></tr></table>	19	PROFESSIONAL FEES		<u>                    </u>
19				

To reclass cost of appealing real estate taxes

Facility Name & ID Number **NORTHSHORE NURSING & REHABILITATION** #0044453 Report Period Beginning: 01/01/00 Ending: 12/31/00

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			22,325	22,325		22,325	(4,224)	18,101			30
31	Amortization of Pre-Op. & Org.			2,520	2,520		2,520		2,520			31
32	Interest			108,831	108,831		108,831	860	109,691			32
33	Real Estate Taxes			102,000	102,000		102,000		102,000			33
34	Rent-Facility & Grounds			1,118,616	1,118,616		1,118,616		1,118,616			34
35	Rent-Equipment & Vehicles			24,347	24,347		24,347		24,347			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,378,639	1,378,639		1,378,639	(3,364)	1,375,275			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	25,305	147,662	184,016	356,983		356,983	(2,393)	354,590			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			148,779	148,779		148,779		148,779			42
43	Other (specify):*	15,568			15,568		15,568	(15,568)				43
44	<b>TOTAL Special Cost Centers</b>	40,873	147,662	332,795	521,330		521,330	(17,961)	503,369			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,609,356	838,574	3,017,959	7,465,889		7,465,889	(195,836)	7,270,053			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

# VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(6,967)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(172)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(72,500)	21		24
25	Fund Raising, Advertising and Promotional	(53,342)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(50,536)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (183,517)		\$	30

OHF USE ONLY							
48		49		50		51	
						52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(12,319)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (12,319)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (195,836)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS  
NORTHSHORE NURSING & REHABILITATION

Page 5A

Report Period Beginning: 01/01/00  
Ending: 12/31/00

NON-ALLOWABLE EXPENSES		Amount	Sch, V Line Reference
1	Deferred Maintenance	\$	6
2	Political Donation	(343)	20
3	Non-Allowable Seminar Expense	(1,186)	24
4	Child Care Expenses	(15,568)	43
5	1999 Legal Fees	(2,023)	19
6	VA Expenses	(31,416)	10
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89			89
90	Total	(50,536)	90

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number **NORTHSHORE NURSING & REHABILITATION**# **0044453**

Report Period Beginning:

**01/01/00**

Ending:

**12/31/00**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary						(407)						(407)	1
2	Food Purchase	(172)					218						46	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance						1						1	6
7	Other (specify):*						11						11	7
8	<b>TOTAL General Services</b>	(172)					(177)						(349)	8
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(31,416)									(1,601)		(33,017)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>	(31,416)									(1,601)		(33,017)	16
	<b>C. General Administration</b>													
17	Administrative						6						6	17
18	Directors Fees													18
19	Professional Services	(2,023)			(51,024)		2						(53,045)	19
20	Fees, Subscriptions & Promotions	(53,685)											(53,685)	20
21	Clerical & General Office Expenses	(72,500)	3,773				6	31,075					(37,646)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,186)											(1,186)	24
25	Other Admin. Staff Transportation						10						10	25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*							4,401					4,401	27
28	<b>TOTAL General Administration</b>	(129,394)	3,773		(51,024)		24	35,476					(141,145)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(160,982)	3,773		(51,024)		(153)	35,476			(1,601)		(174,511)	29

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number NORTHSHORE NURSING & REHABILITATION # 0044453 Report Period Beginning: 01/01/00 Ending: 12/31/00

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(6,967)								2,743			(4,224)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest									860			860	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	(6,967)								3,603			(3,364)	37
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						7			(2,400)			(2,393)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(15,568)											(15,568)	43
44	<b>TOTAL Special Cost Centers</b>	(15,568)					7			(2,400)			(17,961)	44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	(183,517)	3,773		(51,024)		(146)	35,476		1,203	(1,601)		(195,836)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
see attached		see attached		see attached		
				Northshore Properties, LLC		Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES
☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	34	Rental Income / Expense	\$ 1,118,974	Northshore Properties, LLC	100.00%	\$ 1,118,974	\$	1
2	V	32	Interest Income / Expense	66,955	Northshore Properties, LLC	100.00%	66,955		2
3	V	33	RE Tax Income / Expense	102,000	Northshore Properties, LLC	100.00%	102,000		3
4	V	21	Bank Charges / Office Exp.		Northshore Properties, LLC	100.00%	3,773	3,773	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,287,929			\$ 1,291,702	\$ * 3,773	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	1 DIETARY	\$	CARE CENTERS, INC.	100.00%	\$ 0	\$	15
16	V	2 FOOD				0		16
17	V	3 HOUSEKEEPING				0		17
18	V	5 UTILITIES				0		18
19	V	6 REPAIRS AND MAINT.				0		19
20	V	7 EMP. BEN. - GEN. SERV.				0		20
21	V	10 NURSING				0		21
22	V	10A THERAPY				0		22
23	V	11 ACTIVITIES				0		23
24	V	12 SOCIAL SERVICES				0		24
25	V	15 EMP. BEN. - HEALTHCARE				0		25
26	V	17 ADMINISTRATIVE				0		26
27	V	19 PROFESSIONAL FEES				0		27
28	V	20 DUES, SUBSCRIPTIONS				0		28
29	V	21 CLERICAL AND GENERAL				0		29
30	V	24 SEMINARS				0		30
31	V	25 AUTO EXPENSE				0		31
32	V	26 INSURANCE				0		32
33	V	27 EMP. BEN. - GEN. ADMIN.				0		33
34	V	30 DEPRECIATION				0		34
35	V	32 INTEREST	0			0		35
36	V	33 REAL ESTATE TAXES				0		36
37	V	34 BUILDING RENT - UNRELATED				0		37
38	V	35 EQUIPMENT RENTAL				0		38
39	Total		\$			\$ 0	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **NORTHSHORE NURSING & REHABILITATION**# **0044453**Report Period Beginning: **01/01/00**Ending: **12/31/00**

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 DIETARY CONS	\$ 0	Care Centers, Inc.	100.00%	\$ 0	\$
16	V	19 ACCOUNTING	12,000			0	(12,000)
17	V	19 ANCIL ADMIN FEE	0			0	
18	V	19 BOOKEEPING	39,024			0	(39,024)
19	V	19 DATA PROCESSING	0			0	
20	V	19 LEGAL	0			0	
21	V	19 MANAGEMENT FEE	0			0	
22	V	19 PROFESSIONAL FEES	0			0	
23	V	20 ADVERTISING	0			0	
24	V	25 REBILL BUS	0			0	
25	V	0				0	
26	V	22 HOME OFFICE PAYROLL TAX	0			0	
27	V	1 REBILL. PAYROLL DIETARY	0			0	
28	V	3 REBILL. PAYROLL HSKPNG	0			0	
29	V	6 REBILL. PAYROLL MAINT.	0			0	
30	V	10 REBILL. PAYROLL NURSING	0			0	
31	V	10A REBILL. PAYROLL THPY CONS.	0			0	
32	V	11 REBILL. PAYROLL ACTIVITIES	0			0	
33	V	12 REBILL. PAYROLL SOC. SERV.	0			0	
34	V	17 REBILL. PAYROLL ADMIN.	0			0	
35	V	21 REBILL. PAYROLL CLERICAL	0			0	
36	V						
37	V						
38	V						
39	Total		\$ 51,024			\$ 0	\$ * (51,024)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **NORTHSHORE NURSING & REHABILITATION**# **0044453**Report Period Beginning: **01/01/00**Ending: **12/31/00**

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
15	V	10 NURSING	\$	CARE CENTERS, INC.		100.00%	\$ 0	\$	15
16	V	15 EMP. BEN HEALTHCARE					0		16
17	V	17 ADMINISTRATIVE					0		17
18	V	27 EMP. BEN GEN. ADMIN.					0		18
19	V	0					0		19
20	V	0					0		20
21	V	0					0		21
22	V	0					0		22
23	V	0					0		23
24	V	0					0		24
25	V	0					0		25
26	V	0					0		26
27	V	0					0		27
28	V	0					0		28
29	V	0					0		29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0	0						35
36	V								36
37	V								37
38	V								38
39	Total		\$				\$ 0	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	1 DIETARY	\$	CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	\$ 113	\$ 113	15
16	V	2 FOOD				218	218	16
17	V	6 MAINTENANCE				1	1	17
18	V	7 EMP. BEN. - GEN. SERV.				11	11	18
19	V	10 NURSING				0		19
20	V	17 ADMINISTRATIVE				6	6	20
21	V	19 PROFESSIONAL FEES				2	2	21
22	V	20 DUES, FEES, SUB.				0		22
23	V	21 CLERICAL & GENERAL				6	6	23
24	V	24 SEMINARS				0		24
25	V	25 TRAVEL				10	10	25
26	V	32 INTEREST				0		26
27	V	35 RENT - EQUIPMENT & VEHICLES				0		27
28	V	39 ANCILLARY ENTERAL SUPPLIES				7	7	28
29	V	1 DIETARY SUPP	520			0	(520)	29
30	V	39 ANCILLARY SUPP				0		30
31	V	0				0		31
32	V	0				0		32
33	V	0				0		33
34	V	0						34
35	V	0	0					35
36	V							36
37	V							37
38	V							38
39	Total		\$ 520			\$ 374	\$ * (146)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	21 CLERICAL AND GENERAL	\$	CARE CENTERS, INC.	100.00%	\$ 31,075	\$ 31,075	15
16	V	27 EMP. BEN. - GEN. SERV. EMP. BEN.				4,401	4,401	16
17	V	0				0		17
18	V	0				0		18
19	V	0				0		19
20	V	0				0		20
21	V	0				0		21
22	V	0				0		22
23	V	0				0		23
24	V	0				0		24
25	V	0				0		25
26	V	0				0		26
27	V	0				0		27
28	V	0				0		28
29	V	0				0		29
30	V	0				0		30
31	V	0				0		31
32	V	0				0		32
33	V	0				0		33
34	V	0						34
35	V	0	0					35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 35,476	\$ * 35,476	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **NORTHSHORE NURSING & REHABILITATION**# **0044453**Report Period Beginning: **01/01/00**Ending: **12/31/00****VII. RELATED PARTIES (continued)**

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	22 EMPLOYEE HEALTH INS.	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 100,005	\$ 100,005	15
16	V							16
17	V							17
18	V							18
19	V	22 EMPLOYEE HEALTH INS.	100,005				(100,005)	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 100,005			\$ 100,005	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **NORTHSHORE NURSING & REHABILITATION**# **0044453**Report Period Beginning: **01/01/00**Ending: **12/31/00****VII. RELATED PARTIES (continued)**

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
15	V	30 DEPRECIATION	\$	VENTLEASE LLC	100.00%	\$ 2,743	\$	2,743	15
16	V	32 INTEREST				860		860	16
17	V								17
18	V								18
19	V	39 ANCILLARY EQUIP RENT	2,400					(2,400)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 2,400			\$ 3,603	\$ *	1,203	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	MEDICALSUPPLIES	\$	XCEL MEDICAL SUPPLY LLC	100.00%	\$ 8,440	\$ 8,440	15
16	V								16
17	V								17
18	V								18
19	V	10	MEDICALSUPPLIES	10,041				(10,041)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 10,041			\$ 8,440	\$ * (1,601)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **NORTHSHORE NURSING & REHABILITATION**# **0044453**Report Period Beginning: **01/01/00**Ending: **12/31/00****VII. RELATED PARTIES (continued)**

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number NORTHSHORE NURSING & REHABILITATION # 0044453 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	relative	Administrative		see attached	1	1.40		\$		1
2	Barry Gans	Administrator	Administrator	35.43	none	40	100.00	Salary	42,524	17-1	2
3	Barry Gans	Administrator	Administrator	35.43	none	40	100.00	Mgmt Fees	36,000	17-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 78,524		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees)  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number NORTHSHORE NURSING & REHABILITATION # 0044453 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number (\_\_\_\_\_) \_\_\_\_\_

Fax Number (\_\_\_\_\_) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number NORTHSHORE NURSING & REHABILITATION # 0044453 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization CARE CENTERS, INC.  
 Street Address 150 FENCL LANE  
 City / State / Zip Code HILLSDALE, IL. 60162  
 Phone Number (708)449-9090  
 Fax Number (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	PATIENT DAYS	1,512,231	32	\$ 128,135	\$ 128,055		\$	1
2	2	FOOD	PATIENT DAYS	1,512,231	32	(27,254)				2
3	3	HOUSEKEEPING	PATIENT DAYS	1,512,231	32	53,695	52,345			3
4	5	UTILITIES	PATIENT DAYS	1,512,231	32	41,192				4
5	6	REPAIRS AND MAINT.	PATIENT DAYS	1,512,231	32	337,107	220,731			5
6	7	EMP. BEN. - GEN. SERV.	PATIENT DAYS	1,512,231	32	51,593				6
7	10	NURSING	PATIENT DAYS	1,512,231	32	650,209	657,173			7
8	10A	THERAPY	PATIENT DAYS	1,512,231	32	125,600	125,524			8
9	11	ACTIVITIES	PATIENT DAYS	1,512,231	32	54,474	54,163			9
10	12	SOCIAL SERVICES	PATIENT DAYS	1,512,231	32	48,011	48,011			10
11	15	EMP. BEN. - HEALTHCARE	PATIENT DAYS	1,512,231	32	112,058				11
12	17	ADMINISTRATIVE	PATIENT DAYS	1,512,231	32	866,963	862,068			12
13	19	PROFESSIONAL FEES	PATIENT DAYS	1,512,231	32	228,254				13
14	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	1,512,231	32	33,513				14
15	21	CLERICAL AND GENERAL	PATIENT DAYS	1,512,231	32	3,087,659	2,709,599			15
16	24	SEMINARS	PATIENT DAYS	1,512,231	32	119,372				16
17	25	AUTO EXPENSE	PATIENT DAYS	1,512,231	32	5,310				17
18	26	INSURANCE	PATIENT DAYS	1,512,231	32	27,429				18
19	27	EMP. BEN. - GEN. ADMIN.	PATIENT DAYS	1,512,231	32	456,163				19
20	30	DEPRECIATION	PATIENT DAYS	1,512,231	32	288,068				20
21	32	INTEREST	PATIENT DAYS	1,512,231	32	311,903				21
22	33	REAL ESTATE TAXES	PATIENT DAYS	1,512,231	32	55,780				22
23	34	BUILDING RENT - UNRELATE	PATIENT DAYS	1,512,231	32	106,673				23
24	35	EQUIPMENT RENTAL	PATIENT DAYS	1,512,231	32	87,772				24
25	TOTALS					\$ 7,249,679	\$ 4,857,669		\$	25

Facility Name & ID Number NORTHSHORE NURSING & REHABILITATION # 0044453 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization CARE CENTERS, INC.  
 Street Address 150 FENCL LANE  
 City / State / Zip Code HILLSDALE, IL. 60162  
 Phone Number (708)449-9090  
 Fax Number (708)449-7070

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number NORTHSHORE NURSING & REHABILITATION # 0044453 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization CARE CENTERS, INC.  
 Street Address 150 FENCL LANE  
 City / State / Zip Code HILLSDALE, IL. 60162  
 Phone Number (708)449-9090  
 Fax Number (708)449-7070

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT ALLOCATION	9	307,262	298,696			1
2	15	EMP. BEN HEALTHCARE	DIRECT ALLOCATION	9	39,980				2
3	17	ADMINISTRATIVE	DIRECT ALLOCATION	24	1,436,904	1,436,850			3
4	27	EMP. BEN GEN. ADMIN.	DIRECT ALLOCATION	24	191,316				4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,975,462	\$ 1,735,546		\$	25

Facility Name & ID Number NORTHSHORE NURSING & REHABILITATION # 0044453 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization CARE CENTERS, INC.  
 Street Address 150 FENCL LANE  
 City / State / Zip Code HILLSIDE, IL. 60162  
 Phone Number ( 708)449-9090  
 Fax Number ( 708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	HEALTH SYSTEMS INC.	2,287,765	28	496,134	378,284	520	113	1
2	2	FOOD	HEALTH SYSTEMS INC.	2,287,765	28	960,501		520	218	2
3	6	MAINTENANCE	HEALTH SYSTEMS INC.	2,287,765	28	4,392		520	1	3
4	7	EMP. BEN. - GEN. SERV.	HEALTH SYSTEMS INC.	2,287,765	28	47,282		520	11	4
5	10	NURSING	HEALTH SYSTEMS INC.	2,287,765	28	700		520		5
6	17	ADMINISTRATIVE	HEALTH SYSTEMS INC.	2,287,765	28	25,000		520	6	6
7	19	PROFESSIONAL FEES	HEALTH SYSTEMS INC.	2,287,765	28	7,428		520	2	7
8	20	DUES, FEES, SUB.	HEALTH SYSTEMS INC.	2,287,765	28	1,836		520		8
9	21	CLERICAL & GENERAL	HEALTH SYSTEMS INC.	2,287,765	28	24,796		520	6	9
10	24	SEMINARS	HEALTH SYSTEMS INC.	2,287,765	28	1,526		520		10
11	25	TRAVEL	HEALTH SYSTEMS INC.	2,287,765	28	43,326		520	10	11
12	32	INTEREST	HEALTH SYSTEMS INC.	2,287,765	28	1,489		520		12
13	35	RENT - EQUIPMENT & VEHIC	HEALTH SYSTEMS INC.	2,287,765	28	2,182		520		13
14	39	ANCILLARY ENTERAL SUPPL	HEALTH SYSTEMS INC.	2,287,765	28	32,397		520	7	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,648,989	\$ 378,284		\$ 374	25

Facility Name & ID Number NORTHSHORE NURSING & REHABILITATION # 0044453 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization CARE CENTERS, INC.  
 Street Address 150 FENCL LANE  
 City / State / Zip Code HILLSDALE, IL. 60162  
 Phone Number (708)449-9090  
 Fax Number (708)449-7070

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	21	CLERICAL AND GENERAL	DIRECT ALLOCATION	100	1	31,075	31,075		31,075
2	27	EMP. BEN. - GEN. SERV. EMP.	DIRECT ALLOCATION	100	1	4,401			4,401
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25	TOTALS					\$ 35,476	\$ 31,075		\$ 35,476

Facility Name & ID Number NORTHSHORE NURSING & REHABILITATION # 0044453 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization CCS EMPLOYEE BENEFITS GROUP, INC.  
 Street Address 4101 W. MAIN ST.  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 847) 674-1180  
 Fax Number ( 847) 673-7741

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION		\$	\$		\$ 100,005	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 100,005	25

Facility Name & ID Number NORTHSHORE NURSING & REHABILITATION # 0044453 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization VENTLEASE LLC  
 Street Address 4101 W. MAIN ST.  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 847) 674-1180  
 Fax Number ( 847) 673-7741

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT ALLOCATION		\$	\$		\$ 2,743	1
2	32	INTEREST	DIRECT ALLOCATION					860	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 3,603	25

Facility Name & ID Number NORTHSHORE NURSING & REHABILITATION # 0044453 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization XCEL MEDICAL SUPPLY LLC  
 Street Address 150 FENCL LANE  
 City / State / Zip Code HILLSDALE, IL. 60162  
 Phone Number (708)449-2330  
 Fax Number (708)449-3236

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	MEDICALSUPPLIES	DIRECT ALLOCATION		\$	\$		\$ 8,440	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 8,440	25

Facility Name & ID Number NORTHSHORE NURSING & REHABILITATION # 0044453 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number NORTHSHORE NURSING & REHABILIT. # 0044453 Report Period Beginning: 01/01/00 Ending: 12/31/00

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Old Kent Bank		X	Line of Credit				1,200,000				34,103	6
7	Shareholders Loans	X						400,000				7,774	7
8													8
9	TOTAL Facility Related						\$	1,600,000			\$	41,877	9
	B. Non-Facility Related*												
10	Supplemental Schedule												10
11	North Shore Properties	X										66,955	11
12	Alloc from Ventlease	X										860	12
13													13
14	TOTAL Non-Facility Related						\$				\$	67,815	14
15	TOTALS (line 9+line14)						\$	1,600,000			\$	109,692	15

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number NORTHSHORE NURSING & REHABILITAT# 0044453

Report Period Beginning:

01/01/00

Ending:

12/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE****A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6	7	8	9	10
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO				Original	Balance			
1							\$	\$			\$
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											
16											
17											
18											
19											
20											
21							\$	\$			\$

Facility Name & ID Number **NORTHSHORE NURSING & REHABILITATION**# **0044453**

Report Period Beginning:

**01/01/00**

Ending:

**12/31/00****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	<b>42,500</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$		2
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>(42,500)</b>	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>144,500</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	<b>102,000</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995		8
	1996		9
	1997		10
	1998	<b>51,100</b>	11
	1999		12

	<b>FOR OHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

Facility Name &amp; ID Number NORTHSHORE NURSING &amp; REHABILITATION

# 0044453

Report Period Beginning:

01/01/00

Ending:

12/31/00

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 48,925 B. General Construction Type: Exterior Frame Number of Stories           

C. Does the Operating Entity? ☐ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Child Care 450 square feet

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☒ YES ☐ NO  
If so, please complete the following:

1. Total Amount Incurred: 12,642 2. Number of Years Over Which it is Being Amortized: 5

3. Current Period Amortization: 2,520 4. Dates Incurred: August 1999

Nature of Costs: Legal Fees from Lawrence Schwartz of \$12,642

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number **NORTHSHORE NURSING & REHABILITATION**# **0044453**

Report Period Beginning:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	<b>PAINT &amp; DECOR</b>			1999	2,530	65	20	127	62	138	9
10	<b>FIXTURES</b>			1999	1,400	400	20	70	(330)	88	10
11	<b>PAINT &amp; DECOR</b>			1999	1,649	42	20	82	40	109	11
12	<b>FIXTURES</b>			1999	7,477	2,136	20	374	(1,762)	530	12
13	<b>BLDG RENOV</b>			1999	22,800	585	20	1,140	555	1,235	13
14	<b>ELEC RENOV</b>			1999	11,411	293	20	571	278	619	14
15	<b>PAINTING &amp; DECOR</b>			1999	2,002	51	20	100	49	117	15
16	<b>PAINT &amp; DECORATING</b>			1999	2,081	53	20	104	51	121	16
17	<b>CARPET</b>			1999	2,689	69	20	134	65	168	17
18	<b>SPRINKLER</b>			1999	1,530	39	20	77	38	103	18
19	<b>ELEVATOR RENOV</b>			1999	5,500	141	20	275	134	298	19
20	<b>CARPET</b>			1999	9,400	241	20	470	229	627	20
21	<b>SIGNS</b>			1999	701	200	20	35	(165)	44	21
22	<b>COUNTERTOP</b>			2000	6,650		20	278	278	278	22
23	<b>ELECTRICAL</b>			2000	2,060		20	86	86	86	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	<b>PAGE 12B TOTALS</b>				25,535			646	646	646	34
35	<b>PAGE 12A TOTALS</b>				130,925			4,379	4,379	4,379	35
36	<b>TOTAL (lines 4 thru 35)</b>				\$ 236,340	\$ 4,315		\$ 8,948	\$ 4,633	\$ 9,586	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **NORTHSHORE NURSING & REHABILITATION**# **0044453**

Report Period Beginning:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	PLUMBING		2000		8,125		20	102	102	102	9
10	CARPETING		2000		200		20	3	3	3	10
11	BLDG RENOV		2000		950		20	12	12	12	11
12	HVAC		2000		954		20	12	12	12	12
13	ELECTRICAL RENOV		2000		1,702		20	21	21	21	13
14	FIRE ALARM SYSTEM		2000		1,668		20	14	14	14	14
15	SMOKE DETECTORS		2000		13,040		20	109	109	109	15
16	CUBICLE CURTAINS		2000		5,024		20	21	21	21	16
17	BLDG RENOVATIONS		2000		16,200		20	810	810	810	17
18	ELECTRICAL RENOV		2000		1,198		20	60	60	60	18
19	FENCE		2000		3,441		20	57	57	57	19
20	WIRING/OUTLETS		2000		12,420		20	518	518	518	20
21	PLUMBING RENOV		2000		4,000		20	133	133	133	21
22	ELEVATOR RENOV		2000		6,431		20	322	322	322	22
23	PLUMBING		2000		4,400		20	73	73	73	23
24	HVAC		2000		4,024		20	34	34	34	24
25	CARPETING		2000		1,465		20	55	55	55	25
26	HVAC RENOV		2000		4,966		20	227	227	227	26
27	WIRING/OUTLETS		2000		11,000		20	504	504	504	27
28	PAINT & DECORATE		2000		620		20	28	28	28	28
29	PAINT & DECORATE		2000		2,146		20	89	89	89	29
30	PAINT & DECORATE		2000		11,507		20	575	575	575	30
31	ELEVATOR RENOV		2000		1,089		20	18	18	18	31
32	HVAC		2000		1,445		20	48	48	48	32
33	PLUMBING RENOV		2000		4,260		20	160	160	160	33
34	PLASTER/ELECTRICAL		2000		5,425		20	226	226	226	34
35	SUMP PUMP		2000		3,225		20	148	148	148	35
36	TOTAL (lines 4 thru 35)				\$ 130,925	\$		\$ 4,379	\$ 4,379	\$ 4,379	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **NORTHSHORE NURSING & REHABILITATION**# **0044453**

Report Period Beginning:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	<b>ELEVATOR MODULE</b>			2000	2,568		20	85	85	85	9
10	<b>CARPETING</b>			2000	1,320		20	61	61	61	10
11	<b>BLDG RENOV</b>			2000	9,500		20	238	238	238	11
12	<b>HVAC</b>			2000	2,080		20	52	52	52	12
13	<b>PLUMBING</b>			2000	7,737		20	161	161	161	13
14	<b>HVAC</b>			2000	1,419		20	30	30	30	14
15	<b>BLDG RENOV</b>			2000	911		20	19	19	19	15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	<b>TOTAL (lines 4 thru 35)</b>				\$ 25,535	\$		\$ 646	\$ 646	\$ 646	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9											9	
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	<b>TOTAL (lines 4 thru 35)</b>				\$	\$		\$	\$	\$	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
20												19
21												20
22												21
23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9											9	
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **NORTHSHORE NURSING & REHABILITATION**# **0044453**

Report Period Beginning:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
20												19
21												20
22												21
23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	<b>TOTAL (lines 4 thru 35)</b>				\$	\$		\$	\$	\$	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
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21												20
22												21
23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	<b>TOTAL (lines 4 thru 35)</b>				\$	\$		\$	\$	\$	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **NORTHSHORE NURSING & REHABILITATION** # **0044453**

Report Period Beginning:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)****C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 46,808	\$ 20,753	\$ 4,681	\$ (16,072)		\$ 5,793	37
38	Current Year Purchases	94,671		4,472	4,472		4,472	38
39	Fully Depreciated Assets							39
40								40
41	<b>TOTALS</b>	\$ 141,479	\$ 20,753	\$ 9,153	\$ (11,600)		\$ 10,265	41

**D. Vehicle Depreciation (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	<b>TOTALS</b>			\$	\$	\$	\$		\$	46

**E. Summary of Care-Related Assets**

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 377,819	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 25,068	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 18,101	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (6,967)	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 19,851	51

\*\*

**F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)**

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	<b>TOTALS</b>	\$	\$	\$	57

**G. Construction-in-Progress**

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

NORTHSHORE NURSING & REHABILITATION  
0044453  
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE  
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
<b>LINE 28: PRIOR YEARS</b>					
Northshore Nursing & Rehab	46,808	18,010	4,681	(13,329)	5,793
Ventlease LLC		2,743		(2,743)	
<b>TOTALS</b>	<b>46,808</b>	<b>20,753</b>	<b>4,681</b>	<b>(16,072)</b>	<b>5,793</b>

**LINE 29: CURRENT YEAR**

Northshore Nursing & Rehab	94,671		4,472	4,472	4,472
Ventlease LLC					
<b>TOTALS</b>	<b>94,671</b>		<b>4,472</b>	<b>4,472</b>	<b>4,472</b>

**LINE 30: FULLY DEPRECIATED**

Northshore Nursing & Rehab					
Ventlease LLC					
<b>TOTALS</b>					

**TOTALS (Should Tie to Totals on Page 13)**

Northshore Nursing & Rehab	141,479	18,010	9,153	(8,857)	10,265
Ventlease LLC		2,743		(2,743)	
<b>TOTALS</b>	<b>141,479</b>	<b>20,753</b>	<b>9,153</b>	<b>(11,600)</b>	<b>10,265</b>

Facility Name & ID Number NORTHSHORE NURSING & REHABILITATION# 0044453

Report Period Beginning:

01/01/00Ending: 12/31/00**XII. RENTAL COSTS****A. Building and Fixed Equipment (See instructions.)**1. Name of Party Holding Lease: American National Bank & Trust Co. as trustee for Trust No. 25-6859

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		<u>271</u>	<u>6/30/99</u>	\$ <u>1,118,616</u>	<u>10</u>		3
4	Additions							4
5								5
6								6
7	TOTAL		<u>271</u>		\$ <u>1,118,616</u>			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease                     .9. Option to Buy: ☒ YES ☐ NO Terms: after 12/1/2005 for \$13,956,500 \***B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO16. Rental Amount for movable equipment: \$ 10,547Description: Copier \$1342, Storage \$6306, Timeclocks \$2899

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Facility Use</u>	<u>1998 Ford Club Wagon</u>	\$ <u>600.00</u>	\$ <u>7,200</u>	17
18	<u>Facility Use</u>	<u>2000 Toyota 4 Runner</u>	<u>549.98</u>	<u>6,600</u>	18
19					19
20					20
21	TOTAL		\$ <u>#####</u>	\$ <u>13,800</u>	21

10. Effective dates of current rental agreement:

Beginning                     Ending                     

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending                      Annual Rent

12.                      /2001 \$ 1,162,24813.                      /2002 \$ 1,236,43214.                      /2003 \$                     \* If there is an option to buy the building,  
please provide complete details on attached  
schedule.\*\* This amount plus any amortization of lease  
expense must agree with page 4, line 34.

Facility Name & ID Number **NORTHSHORE NURSING & REHABILITATION** # **0044453** Report Period Beginning: **01/01/00** Ending: **12/31/00**  
**XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE _____
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$

**D. NUMBER OF AIDES TRAINED**

<b>COMPLETED</b>	
1. From this facility	
2. From other facilities (f)	
<b>DROP-OUTS</b>	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 73,043	\$		\$ 73,043	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			19,688			19,688	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			91,284			91,284	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				113,967		113,967	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	**SEE SUPPLEMENTAL Other (specify): SCHEDULE**	39-1, 39-2		25,305			33,696		25,305 33,696	13
14	TOTAL			\$ 25,305		\$ 184,015	\$ 147,663		\$ 356,983	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

**SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES**

<u>Special Services - Supplies (Column 6 - Other)</u>	<u>Amount</u>
1 Medical Supplies	247
2 Radiology	2,280
3 Lab	1,521
4 Ambulance	7,680
5 Respiratory Supplies	4,263
6 Air Bed	14,705
7 Vent Equipment	3,000
8	
9	
10	

33,696

<u>Outside Therapies (Column 5 - Other)</u>	<u>Amount</u>
1 Respiratory Therapy	
2	
3	
4	
5	
6	
7	
8	
9	
10	

	1	2	
	Operating	After Consolidation*	
<b>A. Current Assets</b>			
1 Cash on Hand and in Banks	\$ 179,975	\$ 180,128	1
2 Cash-Patient Deposits	11,290	11,290	2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,592,046	1,592,046	3
4 Supply Inventory (priced at )			4
5 Short-Term Investments	9,225	9,225	5
6 Prepaid Insurance	132,346	132,346	6
7 Other Prepaid Expenses			7
8 Accounts Receivable (owners or related parties)	403,997	403,997	8
9 Other(specify): See supplemental schedule	167,448	167,448	9
<b>TOTAL Current Assets</b>			
10 (sum of lines 1 thru 9)	\$ 2,496,327	\$ 2,496,480	10
<b>B. Long-Term Assets</b>			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land			13
14 Buildings, at Historical Cost	61,104	61,104	14
15 Leasehold Improvements, at Historical Cos	95,186	95,186	15
16 Equipment, at Historical Cost	221,527	221,527	16
17 Accumulated Depreciation (book methods)	(22,325)	(22,325)	17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs	12,642	12,642	19
Accumulated Amortization -			
20 Organization & Pre-Operating Costs	(3,570)	(3,570)	20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):			22
23 Other(specify): See supplemental schedule			23
<b>TOTAL Long-Term Assets</b>			
24 (sum of lines 11 thru 23)	\$ 364,564	\$ 364,564	24
<b>TOTAL ASSETS</b>			
25 (sum of lines 10 and 24)	\$ 2,860,891	\$ 2,861,044	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26 Accounts Payable	\$ 497,307	\$ 501,304	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable	1,600,000	1,600,000	29
30 Accrued Salaries Payable	297,266	297,266	30
Accrued Taxes Payable			
31 (excluding real estate taxes)	91,506	91,506	31
32 Accrued Real Estate Taxes(Sch.IX-B)	144,500	144,500	32
33 Accrued Interest Payable			33
34 Deferred Compensation	1,526	1,526	34
35 Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>			
36 See supplemental schedule	3,064	3,064	36
37			37
<b>TOTAL Current Liabilities</b>			
38 (sum of lines 26 thru 37)	\$ 2,635,169	\$ 2,639,166	38
<b>D. Long-Term Liabilities</b>			
39 Long-Term Notes Payable			39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>			
43 See supplemental schedule			43
44			44
<b>TOTAL Long-Term Liabilities</b>			
45 (sum of lines 39 thru 44)	\$	\$	45
<b>TOTAL LIABILITIES</b>			
46 (sum of lines 38 and 45)	\$ 2,635,169	\$ 2,639,166	46
<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 225,722	\$ #REF!	47
<b>TOTAL LIABILITIES AND EQUITY</b>			
48 (sum of lines 46 and 47)	\$ 2,860,891	\$ #REF!	48

\*(See instructions.)

**As of 12/31/00**

OTHER CURRENT ASSETS:	<u>Amount</u>	<u>Amount</u>	OTHER CURRENT LIABILITIES:	<u>Amount</u>	<u>Amount</u>
Real Estate Tax Escrow	144,500		Due to Prior Owner	3,064	
Employee Advances	22,948				
	<u>167,448</u>	<u></u>		<u>3,064</u>	<u></u>
OTHER NON CURRENT ASSETS:			OTHER NON CURRENT LIABILITIES:		
Construction In Progress					
Utility Deposit					
Loan Costs					
	<u></u>	<u></u>		<u></u>	<u></u>
	<u></u>	<u></u>		<u></u>	<u></u>

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>160,637</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<a href="#">Schedule attached</a>		<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>160,637</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>65,085</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>65,085</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>225,722</b>	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name & ID Number	NORTHSHORE NURSING & REHAB#	0044453	Report Period Beginning:	01/01/00	Ending:	12/31/00
---------------------------	-----------------------------	---------	--------------------------	----------	---------	----------

Balance per General Ledger	160,637
----------------------------	---------

Adjustments:

-

-

-

Total adjustments

-

Balance - Beginning of Year

160,637

Equity(Deficit) from Page 17 Col 1

225,722

Related Party

Equity(Deficit)

-71

Income

-3773

(3,844)

Combined Equity - End of Year

221,878

Facility Name &amp; ID Number NORTHSHORE NURSING &amp; REHABILITATION # 0044453 Report Period Beginning: 01/01/00

Ending: 12/31/00

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1			
	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 7,259,102	1
2	Discounts and Allowances for all Levels	(1,263,566)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,995,536	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	972,889	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 972,889	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	131,809	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	5,236	20
21	Other Medical Services	425,504	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 562,549	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<a href="#">See supplemental schedule</a>		28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,530,974	30

2			
	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,358,196	31
32	Health Care	2,915,604	32
33	General Administration	1,292,120	33
	<b>B. Capital Expense</b>		
34	Ownership	1,378,639	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	372,551	35
36	Provider Participation Fee	148,779	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,465,889	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	65,085	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 65,085	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? [not complete](#) If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

DESCRIPTION	AMOUNT
1 Vending Commissions	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
TOTALS	

Facility Name & ID Number **NORTHSHORE NURSING & REHABILITATION**# **0044453**Report Period Beginning: **01/01/00**

Ending:

**12/31/00****XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,208	2,288	\$ 59,203	\$ 25.88	1
2	Assistant Director of Nursing	2,208	2,272	50,803	22.36	2
3	Registered Nurses	28,845	32,129	646,124	20.11	3
4	Licensed Practical Nurses	21,058	22,266	332,625	14.94	4
5	Nurse Aides & Orderlies	124,940	133,739	1,262,879	9.44	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	992	1,067	25,305	23.72	7
8	Rehab/Therapy Aides	9,791	10,813	125,516	11.61	8
9	Activity Director	2,192	2,395	36,182	15.11	9
10	Activity Assistants	16,023	17,056	102,072	5.98	10
11	Social Service Workers	5,992	7,000	67,140	9.59	11
12	Dietician					12
13	Food Service Supervisor	2,064	2,272	39,497	17.38	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,639	30,939	200,468	6.48	15
16	Dishwashers					16
17	Maintenance Workers	3,280	3,600	56,695	15.75	17
18	Housekeepers	36,591	38,510	255,698	6.64	18
19	Laundry	10,356	11,121	73,149	6.58	19
20	Administrator	2,192	2,256	42,524	18.85	20
21	Assistant Administrator	962	1,034	20,361	19.69	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,446	15,765	178,844	11.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,128	2,272	18,703	8.23	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Child Care</u>	1,516	1,630	15,568	9.55	33
34	TOTAL (lines 1 - 33)	316,423	340,424	\$ 3,609,356 *	\$ 10.60	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	347	\$ 15,279	1-3	35
36	Medical Director	monthly	13,640	9-3	36
37	Medical Records Consultant	monthly	4,016	10-3	37
38	Nurse Consultant	56	2,811	10-3	38
39	Pharmacist Consultant	monthly	4,149	10-3	39
40	Physical Therapy Consultant	41	2,250	10A-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	60	2,752	11-3	44
45	Social Service Consultant	28	1,250	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	531	\$ 46,147		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	64	\$ 2,677	10-3	50
51	Licensed Practical Nurses	173	5,353	10-3	51
52	Nurse Aides	1,102	18,735	10-3	52
53	TOTAL (lines 50 - 52)	1,339	\$ 26,765		53

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
DAY CARE / CHILD CARE		\$ 15,568	\$
0	0	\$ 15,568	\$ #DIV/0!

## XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Barry Gans	Administrator	35.43	\$ 42,524
Mary Claussen (9/15-12/31)	Asst. Admin.	0	20,361
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 62,885
B. Administrative - Other			
Description			Amount
Barry Gans - Management Fees			\$ 36,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 36,000
C. Professional Services			
Vendor/Payee	Type		Amount
Frost, Ruttenberg & Rothblatt	Accounting		\$ 9,500
Care Centers, Inc.	Accounting		12,000
Alpha Data	Data Processing		5,250
Winston & Strawn	Legal		3,233
Meyer Megence	Legal		1,156
Stone, McGuire	Legal		83
Lawrence Y. Schwartz	Legal		1,320
Personnel Planners	Unemployment Tax Cons.		1,391
Care Centers, Inc.	Bookkeeping		39,024
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 72,957
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 73,584
Unemployment Compensation Insurance			29,474
FICA Taxes			269,766
Employee Health Insurance			100,005
Employee Meals			41,812
Illinois Municipal Retirement Fund (IMRF)*			
Misc. Employee Welfare			11,517
Pension Expense			24,225
Christmas Expense			10,310
TOTAL (agree to Schedule V, line 22, col.8)			\$ 560,693
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			14,670
Health Care Worker Background Check (Indicate # of checks performed 129 )			1,292
Advertising & Promotion			53,342
Dues & Subscriptions			9,816
Licenses & Fees			9,156
Less: Public Relations Expense		(	)
Non-allowable advertising			(53,342)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 34,934
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			1,945
Entertainment Expense		(	)
TOTAL (agree to Sch. V, line 24, col. 8)			\$ 1,945

\* Attach copy of IMRF notifications

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**  
(See instructions.)

[illegible]

Facility Name &amp; ID Number NORTHSHORE NURSING &amp; REHABILITATION

# 0044453

Report Period Beginning: 01/01/00

Ending: 12/31/00

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. Illinois Council on Long Term Care \$3344
- (3) Did the nursing home make political contributions or payments to a political organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,506 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 148,779  
This amount is to be recorded on line 42 of Schedule V
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 41,812 Has any meal income been offset against related costs? NO Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% In 1  
d. Have vehicle usage logs been maintained? YES  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees.

Date: 07/17/2000

To: Administrator/Cost Report Preparer

From: Office of Health Finance

Re: 2000 Long Term Care Cost Report and Instructions on Diskette  
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to be entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

**WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.**

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "All Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

#### **Notes Applicable only to Lotus users**

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu bar after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use File-Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

#### **Notes Applicable only to Excel users**

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been sealed, you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can go to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/rw